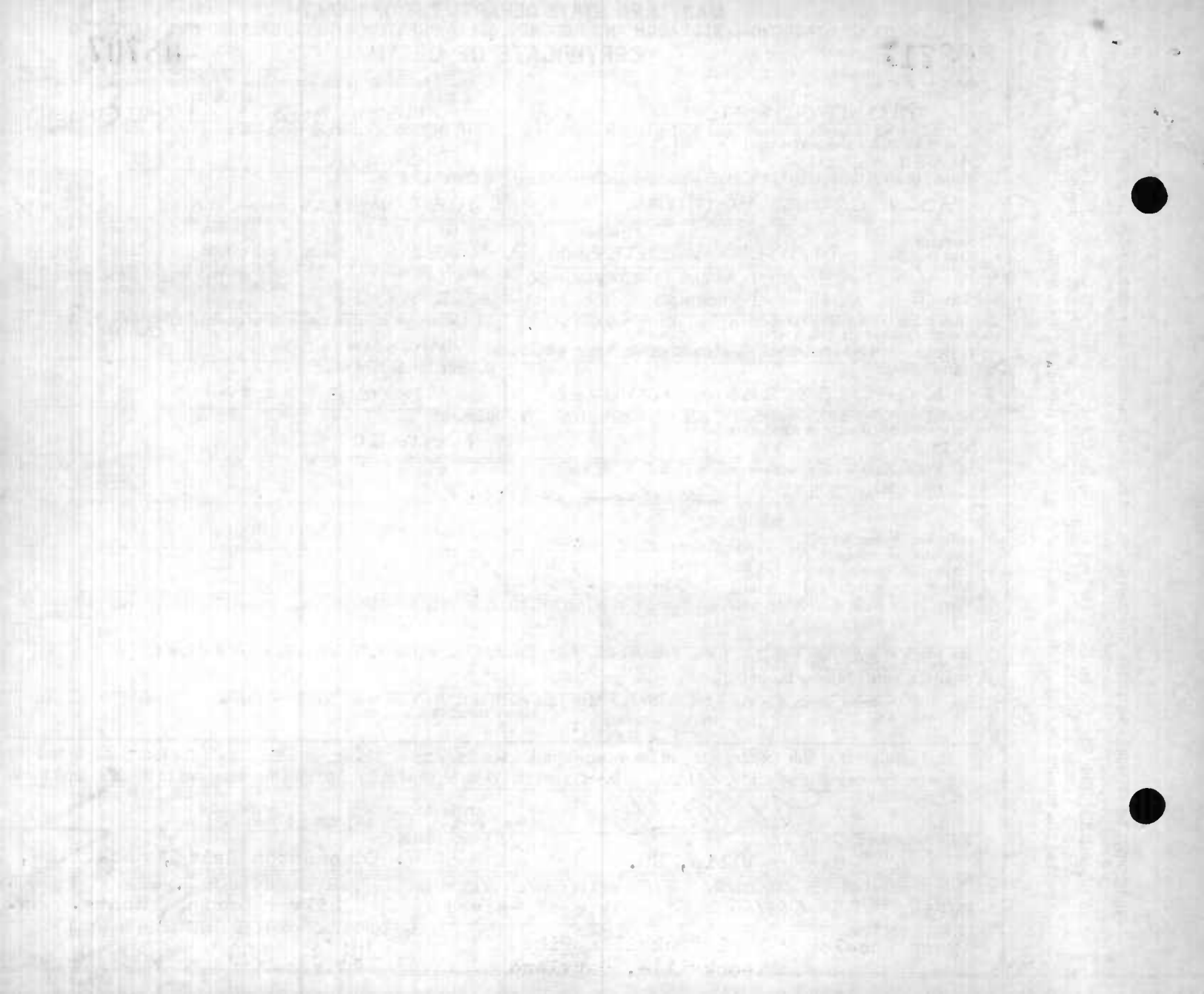


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL						d. STREET ADDRESS 263 CONGRESSIONAL LANE					
3. NAME OF DECEASED (Type or print) First NIHIL Middle ESTEBAN Last RAMIREZ						4. DATE OF DEATH Month JUNE Day 29 Year 1966					
5. SEX MALE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-29-66		9. AGE (In years last birthday) yrs. 2 Months 2 Days 2 Hours 1 Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE MANAGER				10b. KIND OF BUSINESS OR INDUSTRY GOODYEAR TIRE + RUBBER				11. BIRTHPLACE (County & State, or foreign country) HAVANA, CUBA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME NIHIL ESTEBAN RAMIREZ						14. MOTHER'S MAIDEN NAME KIRIE OTA					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NO		17. INFORMANT MOTHER				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 774 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anoxia DUE TO (c) Immaturity										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6-29-1966 , to 6-29-1966 , that (I) (we) last saw the deceased alive on 6-29-1966 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE [Signature]						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) George Ellis, Sr.						22d. ADDRESS 50 W. Edmondston Drive, Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/2/66		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City, town or county) (State) Silver Spring Montg. Md.			
24. FUNERAL DIRECTOR Tyson Wheeler						25a. REC'D BY REGISTRAR JUL 8 1966					
ADDRESS 1331 Rockville Pike Rockville, Maryland						25b. REGISTRAR'S SIGNATURE [Signature]					



08713

CERTIFICATE OF DEATH

08708

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>15-1</u> d. STREET ADDRESS <u>12201 Village Green</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward Joseph Reardon</u> First Middle Last 4. DATE OF DEATH <u>June 23 1966</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIAGE STATUS <u>WIDOWED</u> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>8-17-01</u> 9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editorial Correspondent</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>News</u> 11. BIRTHPLACE (County & State, or foreign country) <u>New York City, NY</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Mark Reardon</u> 14. MOTHER'S MAIDEN NAME <u>Naughton, Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>149-10-2303</u> 17. INFORMANT <u>Daughter</u> Address <u>Springfield, Va. 22150 Gay St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBARACHNOID HEMORRHAGE, (R) MIDDLE CEREBRAL</u> 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>14 HOURS</u> <u>2 YEARS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS AND (L) CAROTID THROMBOSIS</u>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>January, 1966</u> , to <u>June 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 22 1966</u> , and that death occurred at <u>145AM</u> , from causes and on the date stated above.	
22a. SIGNATURE <u>Fredrick S. Caldwell</u> 22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S. CALDWELL</u>		22b. DATE SIGNED <u>23 June 1966</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>50 W. EDMONDSTON DR ROCKVILLE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>6-27-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Fairfax Va</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>JUN 27 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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08208

08173

CERTIFICATE OF DEATH

08719

08709

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>University Park, Md - 16-2</u>	
c. LENGTH OF STAY IN lb <u>10 days</u>		d. STREET ADDRESS <u>4425 Underwood St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fannie Mason Rector</u>		4. DATE OF DEATH Month Day Year <u>June 23 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/24</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James A. Goodwin</u>		14. MOTHER'S MAIDEN NAME <u>Emily F. Mason</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bacterial infection</u> DUE TO (c) <u>Hypostatic pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u> <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/13</u> , 19 <u>63</u> , to <u>6/23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/22</u> 19 <u>63</u> and that death occurred at <u>3:22</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Kenneth Cruze</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>6/23/66</u>
22c. PHYSICIAN'S NAME (Type) <u>Kenneth Cruze md</u>		22d. ADDRESS <u>4600 Carroll Ave Takoma Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-27-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave, N.W. Wash. D.C.</u>		25. REC'D BY REGISTRAR <u>JUN 27 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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08380

CERTIFICATE OF DEATH

1918

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CERTIFICATE OF DEATH

08720

08710

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Potomac Manor Nursing Home</u>				d. STREET ADDRESS <u>319 Wash Blvd</u>			
3. NAME OF DECEASED (Type or print) <u>Edith Ellen Redmiles</u>				4. DATE OF DEATH <u>6 25 1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 25 1879</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William Leishure</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Ann Turner</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>MISS GEORGE SMITH, Laurel, Md.</u>				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Coronary arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/24/66</u> to <u>6/25/66</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>6/24/66</u> and that death occurred at <u>11:45 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Stephen N. Jones</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES</u>				22d. ADDRESS <u>Rockville, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-28-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loy Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Laurel Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Donaldson</u> ADDRESS <u>Laurel Md</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUN 30 1966</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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0/11/19

0/11/19

Edith Ellen Griffiths

1/11/19
1/11/19
2/11/19

My dear Mr. Griffiths
I have just received your letter of the 11th inst. and am glad to hear from you. I am well and hope this finds you the same.

1/11/19
1/11/19
2/11/19

Yours faithfully
Edith Ellen Griffiths

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
08721					08711									
Item 17 Film Q378					6/20/66 mb									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fulton</u>									
c. LENGTH OF STAY IN 1b <u>4 days</u>					d. STREET ADDRESS <u>Pindell School Road</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>E.</u> Last <u>Remmer</u>					4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1966</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/20/1885</u>		9. AGE (In years last birthday) <u>80</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>none</u>					17. INFORMANT <u>Albert William H. Remmer</u> Same as #2 (son)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLI, MULTIPLE</u> 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROSIS, GENERAL</u> DUE TO (c) <u>PERNICIOUS ANEMIA, UNTREATED</u>										INTERVAL BETWEEN ONSET AND DEATH <u>UNK.</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PERNICIOUS ANEMIA, UNTREATED</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>24 MAY</u> , 19 <u>66</u> , to <u>2 JUNE</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>31 MAY</u> , 19 <u>66</u> , and that death occurred at <u>1:35</u> AM, from the causes and on the date stated above.										22a. SIGNATURE <u>Richard Compton</u>		22b. DATE SIGNED <u>2 June 66</u>		
22c. PHYSICIAN'S NAME (Type) <u>J. RICHARD COMPTON MD</u>					22d. ADDRESS <u>612 MAIN ST. LAUREL, MD</u>					22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>6/4/66</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>				
23d. LOCATION (City, town or county) (State) <u>Colmar Manor P.G. Md.</u>					23e. REC'D BY REGISTRAR <u>JUN 6 1966</u>					23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Md.</u>										24b. REGISTRAR'S SIGNATURE				

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08722

08712

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15-1</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>		d. STREET ADDRESS <u>6015 Dellwood Place</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Elise</u> Middle <u>Browning</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-26-90</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u> IF UNDER 24 HRS. Hours <u>15</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pu. Co - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Clay Browning</u>		14. MOTHER'S MAIDEN NAME <u>Blanchette Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-54-1369</u>	
17. INFORMANT <u>Gail Richardson</u>		Address <u>Home</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asphyxiation</u> (c) <u>Asphyxiation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-27-66</u> , 19 <u>66</u> , to <u>6-8-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-8-66</u> , 19 <u>66</u> , and that death occurred at <u>440</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Alan J. Chenery</u>		22b. DATE SIGNED <u>6-8-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Alan J. Chenery</u>		22d. ADDRESS <u>915 19th St. N.W. Wash., D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>6-9-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Wash., D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 13 1966</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

08723

08713

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 5 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS RFD 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Magruder Last Riggs				4. DATE OF DEATH Month June Day 28 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-87 1877	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwards, Waters				14. MOTHER'S MAIDEN NAME Columbia Magruder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hosp. Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 442X DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Cardio-vascular-renal Disease DUE TO with hypertension. (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 day 30 years 30 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Francis H. Barber attended the deceased from 1935 , 19 to 6/28/66 , 19, that (I) see lost saw the deceased alive on 6/28/66 , 19, and that death occurred at 5 a M, from causes on and on the date stated above.							
22a. SIGNATURE M. McKendree Boyer, M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Dr. M.M. Boyer	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 30 1966		23c. NAME OF CEMETERY OR CREMATORY Goshen		23d. LOCATION (City or Town) (County) (State) Laytonsville Mont. Md	
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville Md		25a. REC'D BY REGISTRAR JUN 30 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Francis M. Barber

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08724

08714

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Norbeck</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Norbeck</u>			
c. LENGTH OF STAY IN 1b. <u>years.</u>				15.1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4516 Muncester Mill Rd.</u>				d. STREET ADDRESS <u>4516 Muncester Mill Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ellen Robinson Riley</u>				4. DATE OF DEATH Month Day Year <u>June 10 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1880</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>—</u>			
13. FATHER'S NAME <u>Phil. C. Riley</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Helen M. Sproesser</u>				Address <u>12826 Holdridge Rd Wheaton Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Bronchial</u> <u>2865</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Malnutrition</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/10/66</u>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/14/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR <u>W. W. Chambers, Inc.</u> ADDRESS <u>8655 Georgia Ave Silver Spring, Md</u>				24a. REC'D BY REGISTRAR <u>JUN 14 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08725		CERTIFICATE OF DEATH				08715			
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 1 yr d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home 22 RANDOLPH RD.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 22 Randolph Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Isabelle Middle Stella Last Robey					4. DATE OF DEATH Month June Day 14 Year 19 66				
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-26-90		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Amos Burriss					14. MOTHER'S MAIDEN NAME Sarah Burriss GATES				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT Hospital Record				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 6000 DUE TO Constrictive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease (c) Pylonephritis, Chronic								INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 18 6/14 6	
21. I certify that (I) (this hospital) attended the deceased from 6/14 , 19 66 , to 6/14 , 19 66 , that (I) (we) lost saw the deceased alive on 6/14 , 19 66 , and that death occurred at 6A M, from causes and on the date stated above.									
22a. SIGNATURE [Signature]					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/14/66		
22c. PHYSICIAN'S NAME (Type) Charles H. Ligon, M. D.					22d. ADDRESS Sandy Spring, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-16-1966		23c. NAME OF CEMETERY OR CREMATORY COLESVILLE, METHODIST			23d. LOCATION (City or Town) (County) (State) COLESVILLE, MARYLAND		
24. FUNERAL DIRECTOR W. W. Chambers & Co Riverdale, Md.					25a. REC'D BY REGISTRAR JUN 16 1966		25b. REGISTRAR'S SIGNATURE [Signature]		

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington b. COUNTY King	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 49 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 2605 109 Place N.E.	
3. NAME OF DECEASED (Type or print) First Middle Last Candace Jean Roetman		4. DATE OF DEATH Month Day Year June 25 19 66	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 October 1949
9. AGE (In years lost birthday) yrs. 16		IF UNDER 1 YEAR Months Days Hours Min. 25 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - -		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State, or foreign country) Minneapolis, Minn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Orvil Roetman		14. MOTHER'S MAIDEN NAME Lavera Jones D.C.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Mr. Orvil Roetman		18. ADDRESS Bellevue, Washington, 2605 109 Place N.E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2043 IMMEDIATE CAUSE (a) Acute Leukemia DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH - - -
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - -	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - -	20f. (City or town) (County) (State) - - -
21. I certify that (I) (this hospital) attended the deceased from May 7, 1966 , to June 25, 1966 , that (I) (we) last saw the deceased alive on June 25, 1966 , and that death occurred at 10:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE J. E. Zimmerman		22b. DATE SIGNED June 26, 1966	
22c. PHYSICIAN'S NAME (Type) J. E. Zimmerman		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 6-28-1966	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City or Town) (County) (State) Portland, Oregon
24. FUNERAL DIRECTOR Joseph Gawler & Sons		25. REC'D BY REGISTRAR 5130 Wisconsin Ave. N.W.	
25a. DATE JUN 30 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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EXHIBIT 10-1000

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. LENGTH OF STAY IN 1b <u>35 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		d. STREET ADDRESS <u>2903</u> <u>2903 Grae Loch Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Son. + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>FERDINAND</u> Last <u>ROSE</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-78</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Congruer for Govt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>George X X X Rose</u>		14. MOTHER'S MAIDEN NAME <u>Emily Delano</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Lillian Rose</u>		Address <u>2903 Grae Loch Rd</u> <u>Laurel, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X Cardio Respiratory Failure</u> DUE TO (b) <u>Cerebral Infarction</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/15/66</u> , 19 <u>66</u> , to <u>6/16/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/15/66</u> , 19 <u>66</u> , and that death occurred at <u>8:55 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Smith, Jr.</u>		22b. DATE SIGNED <u>6/16/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Smith, Jr.</u>		22d. ADDRESS <u>Burtonsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>18 June 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>	
25a. REC'D BY REGISTRAR <u>JUN 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

08213

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>						d. STREET ADDRESS <u>6124 Durbin Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Blume</u>			First			Middle			Last		
4. DATE OF DEATH <u>June 13 1966</u>			Month			Day			Year		
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 2, 1888</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SHEA UHLMAN</u>						14. MOTHER'S MAIDEN NAME <u>BRINA GREEN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>SON-IN-LAW</u> Address <u>6124 DURBIN RD. BETH. MD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>?</u> <u>6 yrs</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 12</u> , 19 <u>66</u> , to <u>June 13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>June 12</u> , 19 <u>66</u> , and that death occurred at <u>1 1/2</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>George Sharpe</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE SHARPE</u>						22d. ADDRESS <u>MD 10511 SUMMIT AVE. KENSINGTON MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-14-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN FALLS CHURCH VA</u>				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <u>Bernard Danzansky and Sons</u>						ADDRESS <u>3501-14th St.</u>		25a. REC'D BY REGISTRAR <u>JUN 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>						d. STREET ADDRESS <i>10109 Portland Road</i>					
3. NAME OF DECEASED (Type or print) <i>Joseph Hunter Ross, Jr.</i>						4. DATE OF DEATH Month <i>June</i> Day <i>7</i> Year <i>1966</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 15, 1899</i>		9. AGE (In years last birthday) <i>66 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Food Broker</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Wholesale Foods</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Joseph H. Ross, Sr.</i>						14. MOTHER'S MAIDEN NAME <i>Violet Parsons</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Marie C. Ross</i>		Address <i>10109 Portland Road Silver Spring, Maryland</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metabolic Acidosis</i> <i>443 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Respiratory failure</i> (c) <i>Hypertensive Arteriosclerotic heart disease</i>								INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Liver Cirrhosis of Liver; Carcinoma of Liver</i>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>4 June, 1966</i> to <i>7 June, 1966</i> that (I) (we) last saw the deceased alive on <i>7 June, 1966</i> , and that death occurred at <i>10:25 AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Thomas P. Fogarty</i>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>7 June 66</i>			
22c. PHYSICIAN'S NAME (Type) <i>Thomas P. Fogarty</i>						22d. ADDRESS <i>1011 University Blvd., E., S.S., Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>June 10, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Prince Georges, Co., Md.</i>			
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>						ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>JUN 13 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08730

08720

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>DOA</u>				d. STREET ADDRESS <u>6006 Conway Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Due B. Rothkopf</u>		First Middle Last		4. DATE OF DEATH <u>June 22 1966</u>		Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 19, 1904</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Falls Church, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rudolph Francis Bartle</u>				14. MOTHER'S MAIDEN NAME <u>Martha Cord Milburn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Sister. Margaret F. Jones - Washington D.C. 20016</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>				22. DATE SIGNED <u>6/22/66</u>			
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>				Address (Street, city, town, or county) <u>Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-27-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>JUN 24 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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CERTIFICATE OF DEATH

08731

08721

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>10 days.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN HOSPITAL Hospital</u>				d. STREET ADDRESS <u>2320 East Gate Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Agnes</u> Last <u>ROWE</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>20</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-1894</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Boston, Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel J. Leary</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Mahoney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>176-07-8939</u>		17. INFORMANT Address <u>See above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19 <u> </u> to <u>6-20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-20</u> , 19 <u>66</u> , and that death occurred at <u>230</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>D.L. Bucy</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-20-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>D.L. Bucy</u>				22d. ADDRESS <u>809 VEIR'S Mill Rd Rockville Md. TA</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 23, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>JUN 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08732

08722

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Rhode Island b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS Bayview Park	
3. NAME OF DECEASED (Type or print) First Martin Middle ROZEN Last		4. DATE OF DEATH Month June Day 16 Year 1966	
5. SEX male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1893
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months 4 Days 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Chelsea, Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Rozen		14. MOTHER'S MAIDEN NAME Anna Rosenberg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes unknown		16. SOCIAL SECURITY NO. 023-05-7677	
17. INFORMANT Mr. Nathan Rozen, 145 Pinkney Street/		Address Mass.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia associated with 2000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) metastatic reticulum cell sarcoma DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from May 8, 1966 to June 16, 1966 , that (X) (we) last saw the deceased alive on June 16, 1966 , and that death occurred at 6:45 A.M. from causes and on the date stated above.			
22a. SIGNATURE James L. Shumaker		22b. DATE SIGNED June 16, 1966	
22c. PHYSICIAN'S NAME (Type) James L. Shumaker, M. D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6-17-66	23c. NAME OF CEMETERY OR CREMATORY Swan Point Crematory	23d. LOCATION (City or Town) (County) (State) Providence, R. I.
24. FUNERAL DIRECTOR Robert A. Pumphrey, 7557 Wisconsin Ave. / Md.		25a. REC'D BY REGISTRAR JUN 20 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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State of Maryland

State of Maryland

Department of the State

Department of the State

Division of Archives and History

Division of Archives and History

Office of the State Archivist

Office of the State Archivist

1000 North E Street

1000 North E Street

Annapolis, Maryland

Annapolis, Maryland

Annapolis, Maryland

Phone (410) 326-7000

Phone (410) 326-7000

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08733

08723

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bethesda-Silver Spring Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5510 Lincoln Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First URSULA Middle POOLE Last RUSSELL		4. DATE OF DEATH Month June Day 1 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1884
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 6 Days 7 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Lawson Poole		14. MOTHER'S MAIDEN NAME Elizabeth Boswell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-01-3440	
17. INFORMANT W.R. Poole		18. ADDRESS 10024 Sinnott Drive Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebrovascular accident 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral arteriosclerosis OUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 11 days years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 22, 1966 to June 1, 1966 , that (I) (we) last saw the deceased alive on May 31, 1966 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert N. Coale		22b. DATE SIGNED June 1, 1966	
22c. PHYSICIAN'S NAME (Type) ROBERT N. COALE		22d. ADDRESS 4429 Bradley Lane, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-3-66	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR JUN 3 1966	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Handwritten notes and text, mostly illegible due to extreme fading and bleed-through from the reverse side of the page. Some faint words like "LAWSON" and "WHITE" are visible.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MONTGOMERY
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08724
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOLY CROSS HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KENSINGTON d. STREET ADDRESS 10404 MUIER PLACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JACOB J. SCHLEIFER		First J. Middle SCHLEIFER Last SCHLEIFER		4. DATE OF DEATH JUNE 19 1966			
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH OCT. 13, 1887		9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 8 Days 6 Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INTERIOR DECORATOR		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) NEW YORK			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MICHAEL SCHLEIFER		14. MOTHER'S MAIDEN NAME ROSE KRETT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WWI		16. SOCIAL SECURITY NO. 579-24-4131		17. INFORMANT Wife MRS. MARGARET SCHLIEFER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 days 4 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from May 1965 , to June 19, 1966 , that (I) (we) last saw the deceased alive on June 18, 1966 , and that death occurred at 9:10 AM , from the causes and on the date stated above.							
22a. SIGNATURE J. Blaine Fitzgerald		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-19-66			
22c. PHYSICIAN'S NAME (Type) J. BLAINE FITZGERALD		22d. ADDRESS 8218 Wisconsin Ave. Bethesda					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-21-1966		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL			
23d. LOCATION (City, town or county) (State) ARLINGTON, VA.							
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS 7557 WISCONSIN AVE. BETHESDA, MARYLAND		25a. REC'D BY REGISTRAR JUN 21 1966			
25b. REGISTRAR'S SIGNATURE J. Charles Judge							

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 15-1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9039 Sligo Creek Parkway		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND f. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 9039 Sligo Creek Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CELIA First Middle Last CELIA SEID		4. DATE OF DEATH Month Day Year June 14, 1966 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Russia
13. FATHER'S NAME Franklin Coopersmith		14. MOTHER'S MAIDEN NAME Froma Bronstein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578 16 0618	
17. INFORMANT Mrs. Beatrice Shereshevsky		Address See Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper GI bleeding due to duodenal ulcer 5410 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) A.S.A.D. coronary insuff. Pul. fibrosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1958 to 6/14 , 19 66 , that (I) (we) last saw the deceased alive on 2/15 , 19 65 , and that death occurred at 3A M, from the causes and on the date stated above.			
22a. SIGNATURE Robert Wechsler M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Robert Wechsler		22d. ADDRESS 1800 Eye St. N.W. Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-15-66	23c. NAME OF CEMETERY OR CREMATORY National Capital Hebrew	23d. LOCATION (City, town or county) (State) Washington, DC
24. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons		25a. REC'D BY REGISTRAR JUN 16 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

08726

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>6 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>119 Sherman Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Irene</u> Last <u>Simcox</u>		4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-20-88</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harvey Hayes</u>	
14. MOTHER'S MAIDEN NAME <u>Myrtle Handy</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Records - Washington San Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Artery Disease - Arteriosclerosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Acute pulmonary-passive congestion</u> INTERVAL BETWEEN ONSET AND DEATH <u>none - 7 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) (County) (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>June 7, 1966</u> , to <u>June 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 7, 1966</u> , and that death occurred at <u>9:45 M.</u> from causes and on the date stated above.	
22a. SIGNATURE <u>Albert H. Grollman</u> M.D.		22b. DATE SIGNED <u>6/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN, M.D.</u>		22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JUNE 10, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cleghorn Valley Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Springth. V.A.</u>
24. FUNERAL DIRECTOR <u>Joseph L. Lynam</u> ADDRESS <u>Manor</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

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RECEIVED THE DEPT

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ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 01-11-01 BY 60322
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Dr. Belden Reap. contacted concerning this death and he authorized me to sign this certificate. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Released by Dr. Reap

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08737

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
c. LENGTH OF STAY IN 1b 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 15-1
d. STREET ADDRESS 8101 EASTERN AVE

3. NAME OF DECEASED (Type or print) First Middle Last JANICE Catherine Simpson
4. DATE OF DEATH Month Day Year 6 4 1966

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2/20/09
9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PERSONAL Mgr Specialist H & Welfare
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Thomas Simpson
14. MOTHER'S MAIDEN NAME Elizabeth Penny

15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN None
16. SOCIAL SECURITY NO. 578-32-5138
17. INFORMANT Address Helen P. Simpson 8101 Eastern Avenue Silver Spring, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) Arterial Hypertension OUE TO (c) Cerebro-sclerosis
INTERVAL BETWEEN ONSET AND DEATH 6 hours Undetermined Undetermined
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 23, 1959, to June 4, 1966, that (I) (we) last saw the deceased alive on June 3, 1966, and that death occurred at 7:37 M, from the causes and on the date stated above.

22a. SIGNATURE George L Ball
22b. DATE SIGNED June 4, 1966
22c. PHYSICIAN'S NAME (Type) George L Ball
22d. ADDRESS 10620 Georgia Ave Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF June 8, 1966
23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery
23d. LOCATION (City, town or county) (State) St. Louis, Missouri

24. FUNERAL DIRECTOR Ellen Carter 8434 Georgia Avenue
25a. REC'D BY REGISTRAR JUN 10 1966
25b. REGISTRAR'S SIGNATURE Charles Judge
Warner E. Pumphrey, Inc. Silver Spring, Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
08738					08728									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Norfolk</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u>									
c. LENGTH OF STAY IN 1b <u>30 days</u>					d. STREET ADDRESS <u>1415 Lead Street</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dorothy Mae Smallwood</u>					4. DATE OF DEATH Month Day Year <u>June 17 1966</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>30 September 1925</u>		9. AGE (In years last birthday) <u>40 yrs.</u>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME <u>Tommy Bond</u>					14. MOTHER'S MAIDEN NAME <u>Cassinda (Unknown)</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT <u>The Medical Records</u> Address <u>The Clinical Center, Bethesda, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hydronephrosis and Hydroureter</u> DUE TO (c) <u>Carcinoma of the Cervix</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2-3 months</u> <u>3 years</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)					21. I certify that <u>NO</u> (this hospital) attended the deceased from <u>18 May</u> , 19 <u>66</u> , to <u>17 June</u> , 19 <u>66</u> , that <u>NO</u> (we) last saw the deceased alive on <u>17 June</u> , 19 <u>66</u> , and that death occurred at <u>1:45 M.</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Joseph C. Farmer, Jr.</u>					22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>June 18, 1966</u>									
22c. PHYSICIAN'S NAME (Type) <u>Joseph C. Farmer, Jr., M.D.</u>					22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>June 22, 1966</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Landing</u>				
23d. LOCATION (City, town or county) (State) <u>Windsor, N. C.</u>					24. FUNERAL DIRECTOR <u>Riddick Funeral Service</u> <u>Joseph L. Riddick</u>					25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>				
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					25c. ADDRESS <u>1036 Chapel</u> <u>Norfolk, Va.</u>					25d. DATE <u>JUN 21 1966</u>				

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The Clinical Center, Bethesda, Maryland

30 September 1964

Dr. J. H. Brown

The Clinical Center, Bethesda, Maryland

Re: [illegible]

Enclosed for you are [illegible]

Very truly yours,

13 [illegible]

14 [illegible]

15 [illegible]

16 [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08739

CERTIFICATE OF DEATH

08729

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 2 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 536 Beall Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Susie Estelle Smith		4. DATE OF DEATH Month Day Year June 25 1966	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 July 1914
9. AGE (In years lost birthday) yrs. 51		10. IF UNOER 1 YEAR Months Days Hours Min. 26 July 1914	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C&P Telephone Co.		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Carolina County, Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Woodford Hilton Sirles		14. MOTHER'S MAIDEN NAME Mary Laura Pugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 223 09 1344	
17. INFORMANT Thomas R. Smith		Address 536 Beall Ave. Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) subarachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 23 , 1966, to June 25 , 1966, that (I) (we) last saw the deceased alive on June 25 , 1966, and that death occurred at 12:25 PM on the date stated above.			
22a. SIGNATURE <i>Gerard M. West</i>		22b. DATE SIGNED June 25, 1966	
22c. PHYSICIAN'S NAME (Type) G.W. West M.D.		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 29, 1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington Va.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR DATE JUN 28 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. + Hospital</u>		d. STREET ADDRESS <u>10126 Greenock Road</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Harold</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 10, 1903</u>
9. AGE (In years lost birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>29</u> Days <u>29</u> Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wales</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>William F. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Tuckwell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Record-Washington San. + Hosp. Takoma Park, Md</u>	
17. INFORMANT <u>Record-Washington San. + Hosp. Takoma Park, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarction</u> DUE TO (b) <u>Cerebral vascular thrombosis deep</u> DUE TO (c) <u>Arteriosclerosis obliterans</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> , 19 <u>66</u> , to <u>6/29</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>6/29</u> , 19 <u>66</u> , and that death occurred at <u>6:40</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Kenneth Cruze</u> M.D.		22b. DATE SIGNED <u>6/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>KENNETH CRUZE</u>		22d. ADDRESS <u>831 Univ. Blvd. Tak Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 1, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md</u>	
24. FUNERAL DIRECTOR <u>J. Arthur Walters, 254 Corner 24th & W L St</u>		25a. RECD BY REGISTRAR DATE <u>JUL 5 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9039 Sligo Creek Pkway.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>B.</u> Last <u>SNURE</u>					4. DATE OF DEATH Month <u>JUNE</u> Day <u>29</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-6-77</u>		9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR: Months <u>29</u> Days <u>15</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert Turner</u>					14. MOTHER'S MAIDEN NAME <u>Anne Brownlie</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Robert J. Snure</u>		Address <u>10004 Markham St. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) <u>Coronary occlusion</u> OUE TO (c) <u>Carcinoma of stomach</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/26, 1966</u> to <u>6/29, 1966</u> , that (I) (we) last saw the deceased alive on <u>6/28, 1966</u> , and that death occurred at <u>9:25 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>A.F. Thibadeau</u>						22b. DATE SIGNED <u>6/29/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>A.F. Thibadeau, M.D.</u>						22d. ADDRESS <u>1011 Glenwood Rd. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>July 2, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>		
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						DATE <u>JUL 5 1966</u>			

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Acute myocardial infarction

Coronary occlusion

Cardiomegaly of stomach

A. T. Thompson, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
08742 08732									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 56 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 83.3 d. STREET ADDRESS 7724 Lee Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Evelyn Middle Priscilla Last Solga					4. DATE OF DEATH Month June Day 1 Year 19 66				
5. SEX Female					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 5 October 1916				
9. AGE (In years last birthday) 49 yrs.					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					11b. KIND OF BUSINESS OR INDUSTRY ---				
12. BIRTHPLACE (County & State, or foreign country) North Dakota					13. CITIZEN OF WHAT COUNTRY? USA				
14. FATHER'S NAME John Martin Burns					15. MOTHER'S MAIDEN NAME Sarah Sharp				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					17. SOCIAL SECURITY NO. 502-09-8255				
18. INFIRMITY The Medical Record					19. Address The Clinical Center, Bethesda, Maryland				
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gluten sensitive enteropathy DUE TO (c) 1 Year									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
22a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					22b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					22d. (City or town) (County) (State)				
21. I certify that (this hospital) attended the deceased from April 6, 1966 , to June 1, 1966 , that (we) last saw the deceased alive on June 1, 1966 , and that death occurred at 2:05 M. from the causes and on the date stated above.									
22a. SIGNATURE W. D. Heizer					22b. DATE SIGNED 2 June 1966				
22c. PHYSICIAN'S NAME (Type) William D. Heizer, MD					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF June 6, 1966				
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery					23d. LOCATION (City, town or county) (State) Alexandria, Virginia				
24. FUNERAL DIRECTOR John W. Demaine					25a. REC'D BY REGISTRAR JUN 6 1966				
25b. REGISTRAR'S SIGNATURE Charles Judge									

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Virginia

Albemarle

1941-1942

July

2 October 1942

North Dakota

Great Plains

The United States

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08743

08733

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURTONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURTONSVILLE	
c. LENGTH OF STAY IN 1b 1 1/2 yrs.		d. STREET ADDRESS 14612 Perrywood Dr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14612 Perrywood Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM F. SOUTHWELL		4. DATE OF DEATH Month June Day 4 Year 1966	
5. SEX Male	6. COLOR OR RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1877
9. AGE (In years last birthday) yrs. 89		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) Retired Farm Executive		11. BIRTHPLACE (County & State, or foreign country) Brooklyn, New York	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Henry Southwell (deceased)	
14. MOTHER'S MAIDEN NAME Jane Kavitt (deceased)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 086-07-7979		17. INFORMANT Address Mr. Francis Matier, same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma DUE TO (b) carcinoma prostate DUE TO (c) years			INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) generalized arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 65 to June , 19 66 that (I) (we) last saw the deceased alive on 6-2 19 66 , and that death occurred at 9 P M, from causes and on the date stated above.			
22a. SIGNATURE J. Joseph Collins		22b. DATE SIGNED 6-4-66	
22c. PHYSICIAN'S NAME (Type) J. JOSEPH COLLINS		22d. ADDRESS 614 Main St. Laurel, Md.	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL	23b. DATE THEREOF June 13, 1966	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery,	23d. LOCATION (City or Town) (County) (State) Valhalla, New York
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland		25. REC'D BY REGISTRAR JUN 9 1966	
26. REGISTRAR'S SIGNATURE Charles Judge		27. REGISTRAR'S NAME Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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08734

CERTIFICATE OF DEATH

08734

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

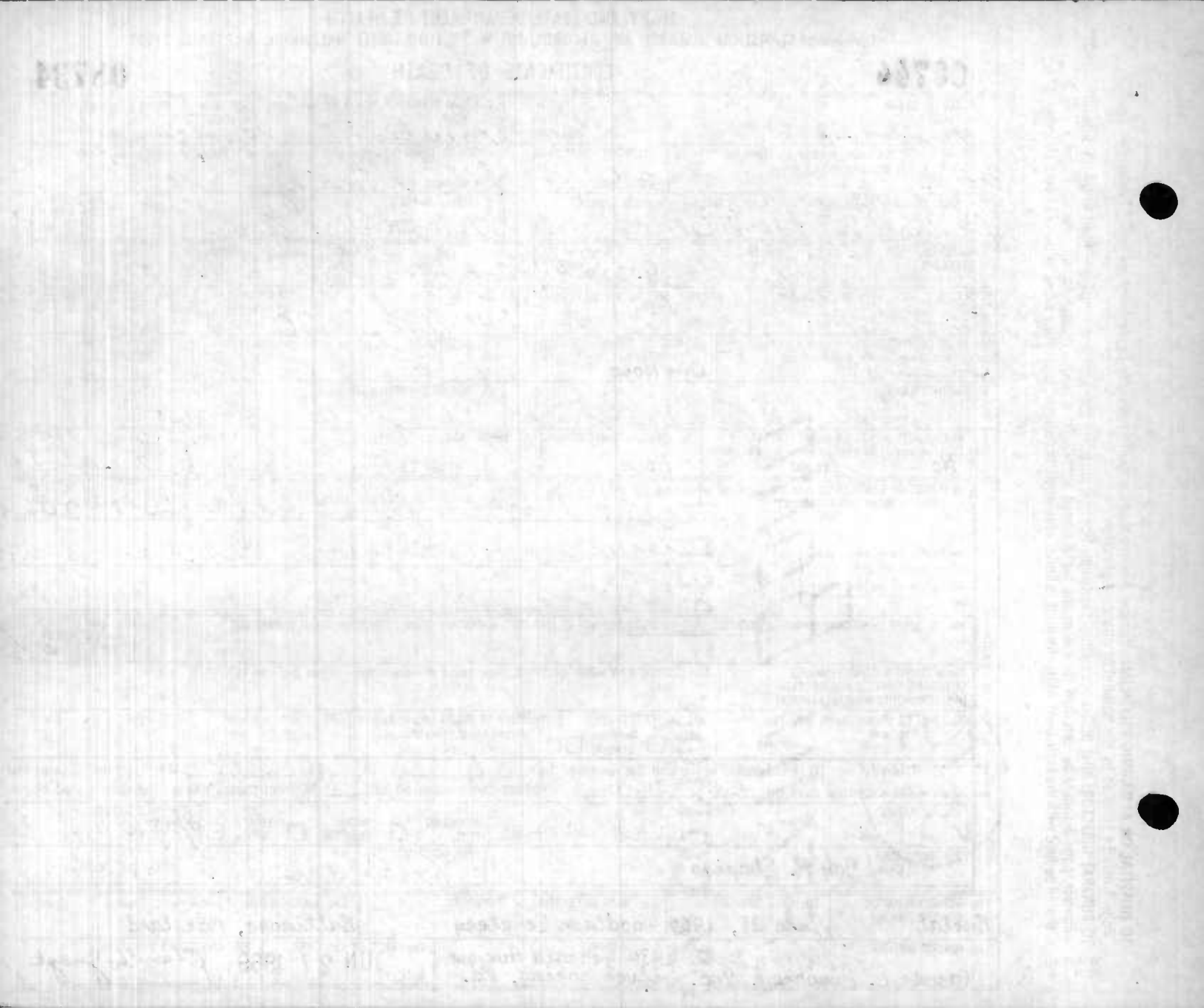
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DuBurban Hospital</u>		d. STREET ADDRESS <u>8758 Georgia Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Edith</u> First <u>GORSUCH</u> Middle <u>Spicknell</u> Last		4. DATE OF DEATH <u>June</u> Month <u>23</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-1896</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Thomas Gorsuch</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Garrett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Dr. John T. Spicknell Jr. Metuchen, N.J.</u>		Address <u>22 Concord Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Acute myocardial infarction</u> DUE TO (b) <u>arteriosclerotic coronary disease</u> DUE TO (c) <u>diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/21/66</u> , 19 <u>66</u> , to <u>6/23/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/23/66</u> , and that death occurred at <u>2:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Jay R. Shapiro MD</u>		22b. DATE SIGNED <u>6/23/66 Bethesda</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jay R. Shapiro</u>		22d. ADDRESS <u>8218 Wisconsin Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 25, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. RECD. BY REGISTRAR DATE <u>JUN 27 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10730

UNITED STATES DEPARTMENT OF THE INTERIOR

10730



CERTIFICATE OF DEATH

08745

08735

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK.</u>		c. LENGTH OF STAY IN 1b <u>7</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM HOSPITAL</u>		d. STREET ADDRESS <u>8106 GARLAND</u>	
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First <u>ANN</u> Middle <u>SPITZMILLER</u> Last		4. DATE OF DEATH <u>36/27/66</u> Month <u>27</u> Day <u>1966</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/94</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR <u>1894</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>JOHN ECKSTEIN</u>		14. MOTHER'S MAIDEN NAME <u>JANE?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>011-3422</u>	
17. INFORMANT <u>MISS ANNA SPITZMILLER</u> Address <u>SAME AS DECEASED</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Acute Pulmonary Edema and Uremic Coma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>June 23</u>	
(b) <u>Acute Congestive Heart Failure</u> DUE TO <u>6 June 27</u>			
(c) <u>Chronic Marked Hypertensive Cardiovascular Disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia & Coma</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 23, 1966</u> , to <u>June 27, 1966</u> that (I) (we) last saw the deceased alive on <u>June 27, 1966</u> , and that death occurred at <u>845 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Wilford D. Meyers M.D.</u>		22b. DATE SIGNED <u>June 27, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilford D. Meyers M.D.</u>		22d. ADDRESS <u>8323 Haddon Dr. Takoma Park Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 30, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 29 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02132

02132

STATE OF TEXAS

John J. Jones

CERTIFICATE OF DEATH

08736

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Henry Last Stinson		4. DATE OF DEATH Month June Day 25 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/95
9. AGE (In years lost birthday) yrs. 71		10. BIRTHPLACE (County & State, or foreign country) Howard, Maryland	
11. CITIZEN OF WHAT COUNTRY? United States		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME William H. Stinson		14. MOTHER'S MAIDEN NAME Estelle Roane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Arteriosclerotic Cardio-vascular-renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) On injury (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yrs plus	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Cirrhosis of Liver, Cholelithiasis, Multiple		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) On injury		20b. HONORABLE CAUSE (Enter nature of injury in Part I or Part II of item 18.) On injury	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from More than 20 yrs to 6/28/66 , 19__, that (I) (we) saw the deceased alive on June 28, 1966 , and that death occurred at 10:17 P.M. 25 M, from causes and on the date stated above.			
22a. SIGNATURE M. McKendree Boyer		22b. DATE SIGNED June 26, 1966	
22c. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M. D.		22d. ADDRESS 9701 Church Street, Damascus, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-28-66	23c. NAME OF CEMETERY OR CREMATORY Oak Grove	23d. LOCATION (City or Town) (County) (State) Glenwood Howard Md.
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.		25a. REC'D BY REGISTRAR JUN 29 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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02738

02738

STATEMENT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08747					08737				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY		
Montgomery		Silver Spring			Maryland		Montgomery		
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
4 days		Haly Cross Hospital			Silver Spring		11603 Idlewood Rd		
e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Middle Last			4. DATE OF DEATH		Month Day Year		
Milfred U. Strippey					June 19 1966				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
F		W				3-2-95		71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR IF UNDER 24 HRS.	
None (Housewife)				Maryland		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
UNKNOWN				UNKNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		NONE		577-20-0256		EUGENE A. STRIPPEY 4703 HIGHWOOD DR SILVER SPRING MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5870 IRREVERSIBLE SHOCK DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute Pancreatitis DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH 24 HRS 24 HRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ARTERIOsclerotic heart Disease									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 4/15, 1966, to 6/19, 1966, that (I) (we) last saw the deceased alive on 6/19, 1966, and that death occurred at 3:45 M, from the causes and on the date stated above.									
22a. SIGNATURE						22b. DATE SIGNED			
Raymond T. Benack						6/19/66			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			
RAYMOND T. BENACK MD						4115 Colie Drive, Wheaton, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)	
BURIAL		6/22/66		ST. PETERS		HARRERS FERRY		WV	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W.W. Chambers Co. 8655 Ga. Ave. S.I. Sping, Md.				JUN 21 1966		J Charles Judge			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

08748

08738

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY in 1b 7 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS Kerger Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Viola Last Strother		4. DATE OF DEATH Month JUNE Day 9 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-85
9. AGE (In years lost birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Charles P. Bailey	
14. MOTHER'S MAIDEN NAME Virginia Best		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown	
16. SOCIAL SECURITY NO.		17. INFORMANT Chart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Cardiac failure, acute + chronic (b) Arteriosclerotic cardiovascular disease (c) Chronic pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH 2-6 mos. 2-4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral vascular accidents, recurrent		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Charles R. Shultz MD		22b. DATE SIGNED 6-9-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 12, 1966	23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery	23d. LOCATION (City or Town) (County) (State) Martinsburg W. Va.
24. FUNERAL DIRECTOR De Witt Carleton, Laurel, Md		25a. REC'D BY REGISTRAR JUN 15 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

255-833

622

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairway Hills c. LENGTH OF STAY IN 1b ?? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6300 Crathie Lane</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairway Hills d. STREET ADDRESS 6300 Crathie Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) JOHN GUICE SUTTON</p>		<p>4. DATE OF DEATH June 20, 1966</p>	
<p>5. SEX Male</p>	<p>6. COLOR OR RACE White</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH July 6, 1902</p>
<p>9. AGE (In years last birthday) 63 yrs.</p>		<p>10. IF UNDER 1 YEAR Months 11 Days 14</p>	<p>11. IF UNDER 24 HRS. Hours 11 Min. 14</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY Gov't</p>	
<p>11. BIRTHPLACE (State or foreign country) Alabama</p>		<p>12. CITIZEN OF WHAT COUNTRY? U. S.</p>	
<p>13. FATHER'S NAME Stephen Sutton</p>		<p>14. MOTHER'S MAIDEN NAME Ada Collins</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No</p>		<p>16. SOCIAL SECURITY NO. 577-60-0650</p>	
<p>17. INFORMANT Wife</p>		<p>Address Same as Item 2.</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency, Acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 DUE TO (c)</p>			<p>INTERVAL BETWEEN ONSET AND DEATH Sudden</p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>			
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>			
<p>ACTUAL SIGNATURE John G. Ball</p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> June 20, 1966 M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Bethesda, Md.</p>	
<p>EXAMINER'S NAME (Type) JOHN G. BALL</p>		<p>Address (Street, city, town, or county)</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>23b. DATE THEREOF 6/23/1966</p>	
<p>23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery</p>		<p>23d. LOCATION (City, town or county) (State) Washington D.C.</p>	
<p>24. FUNERAL DIRECTOR Robert A. Pumphrey</p>		<p>ADDRESS Bethesda, Maryland</p>	
<p>25a. REC'D BY REGISTRAR JUN 23 1966</p>		<p>25b. REGISTRAR'S SIGNATURE J Charles Judge</p>	

Robert A. Humphrey Bethesda, Maryland JUN 23 1962
Burial 6/23/1962 Rock Creek Cemetery Washington D.C.

08750

CERTIFICATE OF DEATH

08740

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN lb <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Stone Ridge Ct.</u>	
3. NAME OF DECEASED (Type or print) <u>DAISY H SWEADNER</u>		4. DATE OF DEATH <u>JUNE 13 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 21-1888</u>
9. AGE (In years last birthday) yrs. <u>78</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Utica Frederick Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN HOLTZOPLE</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE LONG</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-03-5895</u>	
17. INFORMANT <u>SM</u> Address <u>LOUIS E SWEADNER</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>6-13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>MAY</u> 19 <u>66</u> , and that death occurred at <u>11:18</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>D.L. Bucy</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>D.L. Bucy</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6/16/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FAIRMOUNT</u>	23d. LOCATION (City or Town) (County) (State) <u>LIBERTYTOWN MD</u>
24. FUNERAL DIRECTOR <u>D. Hartzler & Sons Libertytown, Md</u>		25a. REC'D BY REGISTRAR <u>JUN 17 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4528

18

08751

CERTIFICATE OF DEATH

08741

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>21 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fredrick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u> d. STREET ADDRESS <u>Box 101 Rt # 2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Burley Taylor</u>		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/05</u> 9. AGE (In years last birthday) <u>61</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursery</u>	11. BIRTHPLACE (County & State, or foreign country) <u>VA.</u>
13. FATHER'S NAME <u>Andrew Taylor</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>414-10-7531</u>	17. INFORMANT <u>Glenn Taylor</u> Address <u>409 Park Rd. Rockville Md.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4201 DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-19</u> , 19 <u>66</u> , to <u>6-9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-9</u> , 19 <u>66</u> , and that death occurred at <u>620</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>D.L. Bucy</u>		22b. DATE SIGNED <u>6-9-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>D.L. Bucy</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/13/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>JUN 13 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

145213

12780

050-91-410

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08752

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08742

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>VIRGINIA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(RIVERDALE) SOUTH BOSTON</u> <u>83-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MELVIN</u> <u>THAXTON</u>				4. DATE OF DEATH Month Day Year <u>JUNE 18,</u> <u>19 66</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/19/46</u>	9. AGE (In years lost birthday) yrs. <u>20</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOBACCO WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FACTORY</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WALTER LEE THAXTON</u>				14. MOTHER'S MAIDEN NAME <u>MARY WALTON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MOTHER per PEOPLES FUNERAL HOME SO. BOSTON</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>8220</u> IMMEDIATE CAUSE (a) <u>fracture, skull, compound, comminuted</u> DUE TO (b) <u>Automobile Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)						INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in dump truck turned over and was thrown out.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10:45</u> <u>6-18</u> <u>1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Tridell</u> <u>Mont.</u> <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Boll</u> M.D.				22. DATE SIGNED <u>6/19/66</u>			
EXAMINER'S NAME (Type) <u>John G. Boll</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>6/20/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>South Boston, Va.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Lowes Funeral Home</u>				25. REC'D BY REGISTRAR <u>JUN 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

522

[illegible]

†h9b19A 011000†:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08753

08743

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>city</u>		c. LENGTH OF STAY IN lb <u>15 mos.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chevy Chase Hunt Home E. W. Highway 1610 Park Rd, Washington, D.C.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bertha</u> First Middle Lost		4. DATE OF DEATH Month <u>6</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25, 1883</u> 9. AGE (In years last birthday) <u>82</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Major Bedford</u>		14. MOTHER'S MAIDEN NAME <u>Staradurski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>123-20-6559A</u>	
17. INFORMANT <u>MRS. JENNE TOURIN</u> Address <u>6111 E. ALBERT RD - BETHESDA - MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>CORONARY Thrombosis</u> DUE TO (c) <u>ARTERIOSCLEROTIC Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>IMMED</u> <u>15 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1948</u> , 19 <u>66</u> , to <u>6-26</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>6-26</u> , 19 <u>66</u> , and that death occurred at <u>6 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William Kurstin MD</u>		22b. DATE SIGNED <u>6/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William Kurstin</u>		22d. ADDRESS <u>916 19th St. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>6-27-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>F.L. LINCOLN CREMATORY</u>	23d. LOCATION (City or Town) (County) (State) <u>COTTAGE CITY MD</u>
24. FUNERAL DIRECTOR <u>Goldberg, Fun Home</u> ADDRESS <u>4217 9 St. N.W.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUN 28 1966</u>			

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THE HOUSE OF DEATH

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JUN 2 1966

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CERTIFICATE OF DEATH

08744

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 30 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15-1			
3. NAME OF DECEASED (Type or print) First Middle Last Lucile Wilson Wahl				4. DATE OF DEATH Month Day Year June 6 19 66			
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1889	9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME A. Wilson				14. MOTHER'S MAIDEN NAME Anna Jordon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 577-05-5865 None		17. INFORMANT Mr. Richard Wahl Address 125 Southwood Avenue Silver Spring, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of lung 165 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 6 , 19 66 , to June 6 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 6 , 19 66 , and that death occurred at 555P M, from causes and on the date stated above.							
22a. SIGNATURE J. Zimmerman				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED June 7, 1966	
22c. PHYSICIAN'S NAME (Type) J. ZIMMERMAN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF June 8, 1966	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.		
24. FUNERAL DIRECTOR W. E. Pumphrey Funeral Home		ADDRESS Spring, Md.		25a. REC'D BY REGISTRAR JUN 13 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

143-11

CONFIDENTIAL

04752

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]
DATE: [Illegible]
FROM: [Illegible]
TO: [Illegible]
[The following text is illegible due to extreme fading and bleed-through from the reverse side of the page.]

[The following text is illegible due to extreme fading and bleed-through from the reverse side of the page.]

CERTIFICATE OF DEATH

08745

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Kansas		b. COUNTY 54-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 117 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wichita		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 121 S. Tracy Street			
3. NAME OF DECEASED (Type or print) Darrell Thomas Walker II				4. DATE OF DEATH Month June Day 15 Year 1966			
5. SEX male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1 December 1943		9. AGE (In years last birthday) yrs. 22	IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min. 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wichita, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Darrell Thomas Walker				14. MOTHER'S MAIDEN NAME Jerry Foraker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1964-1966		16. SOCIAL SECURITY NO. 510 38 5794		17. INFORMANT Wichita, Kansas Mrs. Jerry Hayes 121 S. Tracy St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lymphoma wide spread Metastasis 2002 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 18, 1966 to June 15, 1966 , that (I) (we) last saw the deceased alive on June 15, 1966 , and that death occurred at 12:15 A.M. from causes and on the date stated above.							
22a. SIGNATURE James L Snyder				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 15 JUNE 1966	
22c. PHYSICIAN'S NAME (Type) J. L. Snyder				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/16/66		23c. NAME OF CEMETERY OR CREMATORY Rest Haven		23d. LOCATION (City or Town) (County) (State) Wichita, Kansas	
24. FUNERAL DIRECTOR W. W. Chambers				25a. REC'D BY REGISTRAR JUN 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02342

02352

U.S. DEPARTMENT OF JUSTICE		FEDERAL BUREAU OF INVESTIGATION	
WASHINGTON, D.C. 20535		OFFICE OF THE ATTORNEY GENERAL	
MEMORANDUM FOR THE ATTORNEY GENERAL		DATE: 10/10/68	
SUBJECT: [Illegible]		RE: [Illegible]	
1. [Illegible]		2. [Illegible]	
3. [Illegible]		4. [Illegible]	
5. [Illegible]		6. [Illegible]	
7. [Illegible]		8. [Illegible]	
9. [Illegible]		10. [Illegible]	
11. [Illegible]		12. [Illegible]	
13. [Illegible]		14. [Illegible]	
15. [Illegible]		16. [Illegible]	
17. [Illegible]		18. [Illegible]	
19. [Illegible]		20. [Illegible]	
21. [Illegible]		22. [Illegible]	
23. [Illegible]		24. [Illegible]	
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27. [Illegible]		28. [Illegible]	
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31. [Illegible]		32. [Illegible]	
33. [Illegible]		34. [Illegible]	
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91. [Illegible]		92. [Illegible]	
93. [Illegible]		94. [Illegible]	
95. [Illegible]		96. [Illegible]	
97. [Illegible]		98. [Illegible]	
99. [Illegible]		100. [Illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08756

08746

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 401 Marigold Ct. Montgomery b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) University Nursing Home				d. STREET ADDRESS 4 Marigold Court 301 Marigold Ct.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Ida		First		Middle Walker		Last	
4. DATE OF DEATH June		Month		Day 15		Year 1966	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/1889	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailoring Business Clothes		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Moses Pinerman				14. MOTHER'S MAIDEN NAME Sarah Potts			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-48-524		17. INFORMANT Morton Walker		Address Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE FAILURE DUE TO (b) METASTATIC CARCINOMA. DUE TO (c) BREAST CARCINOMA. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL, 1966 , to 6-15-1966 , that (I) (we) last saw the deceased alive on 6-15-1966 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert Kramer				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Robert Kramer M.D.	
22d. ADDRESS 8484 16th St. 88 Ad.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-17-1966		23c. NAME OF CEMETERY OR CREMATORY Adas Israel Cemetery		23d. LOCATION (City, town or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR Oldberg Funeral Home				24a. ADDRESS 4217-9th St. 4		24b. REC'D BY REGISTRAR JUN 17 1966	
24c. REGISTRAR'S SIGNATURE Charles Judge				24d. ADDRESS			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase 20015</u> d. STREET ADDRESS <u>6700 Hillandale Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KATHERINE G.</u> Middle <u>WALLER</u> Last <u>WALLER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> LEGAL SEPARATION <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 19 1943</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ALLSCHALMERS</u>	9. AGE (In years last birthday) <u>23</u> yrs. IF UNDER 1 YEAR Months <u>4</u> Days <u>16</u> Hours <u></u> Min. <u></u>
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ERNEST A GRAVES</u>		14. MOTHER'S MAIDEN NAME <u>HOUSE KLEE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-38-2935</u>	
17. INFORMANT <u>MOTHER</u> Address <u>BETHESDA</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage.</u> 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of Aneurysm Anterior Cerebral</u> DUE TO (c) <u>Artery - Congenital.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bethesda, Md.</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/5/66</u> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-7-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUN 8 1966</u>	25b. REGISTRAR'S SIGNATURE <u>g Charles Judge</u>

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Gray Chase 20010

212-18-2025

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08758

08748

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shannon Nursing Home			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D. C. d. STREET ADDRESS 1613 - 35th Street N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Delbert Middle Moody Last Wells			4. DATE OF DEATH Month June Day 1 Year 1966		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/1874		9. AGE (In years last birthday) 91 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Builder		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Unobtainable			14. MOTHER'S MAIDEN NAME --Buckingham		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Address Washington, DC Agatha W. Wilken - 1613 35th St. N. W.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4-5 days					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from JANUARY 6, 1964 to 1 June, 1966 that (I) (we) last saw the deceased alive on 5/28 19 66 , and that death occurred at 10:25 AM from the causes and on the date stated above.					
22a. SIGNATURE William D. Aud			22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) William D. Aud
22d. ADDRESS 9006 Colesville Road			22e. ADDRESS Silver Spring Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/3/66	23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery	23d. LOCATION (City, town or county) Washington, D. C.		
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company			25a. REC'D BY REGISTRAR JUN 3 1966		
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
08759					CERTIFICATE OF DEATH					08749				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>			c. LENGTH OF STAY IN lb <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> 15-1									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deburban</u>					d. STREET ADDRESS <u>Rt #2</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Stuart</u> Middle <u>C. Whisman</u> Last <u></u>					4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1966</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/16/12</u>		9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanics</u>					10b. KIND OF BUSINESS, OR INDUSTRY <u>Mont Co. Gov.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Maico</u>					14. MOTHER'S MAIDEN NAME <u>Whisman</u> <u>Perlina</u> <u>Waddell</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>220-09-2600</u>		17. INFORMANT <u>Wife</u> <u>Flora Mae Whisman</u>			Address <u>as above</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary thrombosis</u> DUE TO <u>arterio sclerosis previous infarction</u> DUE TO <u>recent sub-total gastrectomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>emphysema advanced</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>6/22/66</u> , 19 <u>66</u> , to <u>6/27</u> , 19 <u>66</u> that (I) (we) lost saw the deceased alive on <u>6/27</u> , 19 <u>66</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above.														
22a. SIGNATURE <u>John O. Robben</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-27-66</u>							
22c. PHYSICIAN'S NAME (Type) <u>John O. Robben MD</u>					22d. ADDRESS <u>10400 CONNECTICUT AVE Kensington</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/1/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>			23d. LOCATION (City or Town) (County) (State) <u>Beallsville Monty Md</u>							
24. FUNERAL DIRECTOR <u>William B. Hilton</u> <u>Barnesville Md</u>					ADDRESS		25a. REC'D BY REGISTRAR DATE <u>JUL 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08760						08750					
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GERMAN TOWN</u> c. LENGTH OF STAY IN b. <u>1 YEAR</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MARYLANDER HOME OF REST, INC.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> <u>162</u> d. STREET ADDRESS <u>6608 NEWPORT RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAURA</u> <u>REBECCA</u> <u>WHITE</u>			4. DATE OF DEATH Month Day Year <u>6</u> <u>30</u> <u>1966</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1876</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ALEXANDRIA, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James T. Walker</u>						14. MOTHER'S MAIDEN NAME <u>Virginia G. ?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Robert B. White Sr.</u> Address <u>6608 Newport Rd. Hyattsville, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Enterosclerotic cardiovascular disease</u> <u>592 X</u> DUE TO (b) <u>Chronic glomerulonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>10 years</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> , 19 <u>65</u> to <u>5/30</u> , 19 <u>66</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>6/7/66</u> , 19 <u>66</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>James P. Kerr</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/30/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>						22d. ADDRESS <u>DAMASCUS</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>JUNE 24, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington Va</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md</u>						25. RECEIVED BY REGISTRAR <u>JUN 27 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

08761

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08752

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jakoma Park</i>		c. LENGTH OF STAY IN 1b <i>D. O. A.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> <i>15-1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>				d. STREET ADDRESS <i>14600 Claude Lane</i>			
3. NAME OF DECEASED (Type or print) First <i>Francis</i> Middle <i>Turner</i> Last <i>Williams</i>				4. DATE OF DEATH Month <i>June</i> Day <i>29</i> Year <i>19 66</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 6, 1907</i>		9. AGE (In years last birthday) <i>59</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bricklayer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Edward Williams</i>				14. MOTHER'S MAIDEN NAME <i>Ella Turner</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-24-5308</i>		17. INFORMANT <i>Dorothy E. Williams</i> Address <i>14600 Claude Lane Silver Spring, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> DUE TO <i>Acute Coronary Insufficiency</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Artery Heart Disease.</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <i>BELDEN R. REAP</i> ADDRESS <i>6/30/1966</i> Address (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>July 2, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>John B. Thomas</i> ADDRESS <i>8434 Georgia Avenue</i> <i>Warner E. Pumphrey, Inc.</i> <i>Silver Spring, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>JUL 5 1966</i>		25b. REGISTRAR'S SIGNATURE <i>JCL/rles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08762 CERTIFICATE OF DEATH 08753

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5062 Park Place		d. STREET ADDRESS 5062 Park Place	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E. Last WISE		4. DATE OF DEATH Month June Day 30 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-1901
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Patrick Wise		14. MOTHER'S MAIDEN NAME Mary Emma Burroughs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - - -		16. SOCIAL SECURITY NO. 579-16-5254	
17. INFORMANT Charles F. Sisson		Address 2754 Woodley Place Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastrointestinal hemorrhage 5410 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Duodenal ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Craniotomy for removal brain tumor (May, 1965) & Rt. hemiplegia		INTERVAL BETWEEN ONSET AND DEATH 11 days ?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-19-1966 to 6-30-1966 that (I) (we) last saw the deceased alive on 6-30-1966 , and that death occurred at 11 M, from the causes and on the date stated above.			
22a. SIGNATURE George A. Gray Jr.		22b. DATE SIGNED 6/1/66	
22c. PHYSICIAN'S NAME (Type) George A. Gray M.D.		22d. ADDRESS Cherry Chase, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-4-1966	
23c. NAME OF CEMETERY OR CREMATORY Methodist Church Cemetery		23d. LOCATION (City, town or county) (State) Potomac, Md.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		25a. REC'D BY REGISTRAR Charles Judge	
25b. ADDRESS 150 Wisc. Ave. N.W. Wash. D.C.		25c. DATE JUL 5 1966	

CERTIFICATE OF DEATH

08763

08754

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington</u> COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Resmaa Sanatorium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sue</u> Middle <u>Belle</u> Last <u>Wiseman</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 15, 1882</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Patrick Francis Sheedy</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Lucas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>John C. Wiseman - son</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u> </u> , to <u>present</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>6/3</u> , 19 <u>66</u> , and that death occurred at <u>3:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>John B. Umhau</u> M.D.		22b. DATE SIGNED <u>6/5/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John B. Umhau</u>		22d. ADDRESS <u>8805 Conn. Ave. Ch. Ch. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>8 June 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOSEPH GAWLERS SONS</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

25

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08764

08755

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 473	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Sanitarium		d. STREET ADDRESS 4201 Mass. Ave., N.W.	
3. NAME OF DECEASED (Type or print) First Lorena Middle M. Last Witt		4. DATE OF DEATH Month June Day 21 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1891
		9. AGE (In years last birthday) yrs. 74	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (County & State, or foreign country) Arizona
12. COUNTRY OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME E.O. Kennedy,	
14. MOTHER'S MAIDEN NAME Elizabeth Phelan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT 4201 Mass. Ave. N.W. Mrs. Nellie K. Ferguson,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Senile Dementia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/21, 1966 to 6/21, 1966 , that (I) (we) last saw the deceased alive on 6/21, 1966 , and that death occurred at 4:55 AM , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED June 21, 1966	
22c. PHYSICIAN'S NAME (Type) W. T. Joyce		22d. ADDRESS 4977 Battery Lane, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF June 23, 1966	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR H. W. DeVol		25a. REC'D BY REGISTRAR 2222 Wis. Ave. N.W. Wash.	
25b. REGISTRAR'S SIGNATURE [Signature]		DATE JUN 24 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6524

4252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>08765</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>08756</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. LENGTH OF STAY IN 1b <u>15-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>						d. STREET ADDRESS <u>13419 Keating St.</u>					
3. NAME OF DECEASED (Type or print) <u>Mrs Mary Ella Wood</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 17, 1918</u>		9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?		13. DATE OF DEATH <u>June 13 1966</u>		14. IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <u>Joseph F Wood</u>						14. MOTHER'S MAIDEN NAME <u>Marjorie Candrey</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.					
17. INFORMANT <u>Washington Sanitarium & Hospital</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1992 Anomition</u> DUE TO (b) <u>Malabsorption of food</u> DUE TO (c) <u>Carcinomatous of abdominal organs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>5 years</u> <u>5 years</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1963</u> , to <u>June 13, 1966</u> that (I) (we) last saw the deceased alive on <u>June 11 1966</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>W.W. Eastman</u>						22b. DATE SIGNED <u>June 13, 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>W.W. EASTMAN M.D.</u>						22d. ADDRESS <u>831 UNIV. BLVD. S. SPRINGS, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>6-16-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEM.</u>		23d. LOCATION (City, town or county) (State) <u>ROCKVILLE, MD.</u>			
24. FUNERAL DIRECTOR <u>JOSEPH GAWLERS SONS</u>						25a. REC'D BY REGISTRAR <u>JUN 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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FOR STATE
HEALTH DEPT.

08766

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08757

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland c. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San. & Hospital		d. STREET ADDRESS 3617 Kirkwood Place	
3. NAME OF DECEASED (Type or print) HERALD JOSEPH WORKMAN		4. DATE OF DEATH 6-8-1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-29-48
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Penn.
13. FATHER'S NAME Joseph L. Workman		14. MOTHER'S MAIDEN NAME Rita Lynagh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph L. Workman		Address 2617 Kirkwood Pl. W. Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental drowning while swimming DUE TO (b) in pool. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Deceased, drinking, unable to get back to shore after swimming.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Swimming pool	
20c. TIME OF INJURY Month, Day, Year 3:45 p.m. 6/8 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Swimming pool		20f. (City or town) (County) (State) Silver Spring Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Leap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. LEAP M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-11-66	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or town) (County) (State) Wheaton, Md.	
24. FUNERAL DIRECTOR W. W. Chambers, Co.		25a. REC'D BY REGISTRAR DAUN 13 1966	
ADDRESS 5801 Cleveland Riverdale, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pertinent item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10580

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08767					08758						
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Campbell						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 50 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lynchburg 83-3						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Maryland					d. STREET ADDRESS 201 Yeardley Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) David		First Wayne		Middle Wright		Last Wright		4. DATE OF DEATH Month June Day 23 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 November 1908		9. AGE (In years last birthday) 57 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Managing Editor			10b. KIND OF BUSINESS OR INDUSTRY Newspaper			11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Luther M. Wright					14. MOTHER'S MAIDEN NAME Marie Parker						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 226-03-7061		17. INFORMANT The Medical Record, Address The Clinical Center, Bethesda 14, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 274X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Retroperitoneal hemorrhage DUE TO (c) Primary aldosteronism 10 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Osteoporosis										INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4 May, 19 66, to 23 June, 19 66, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 23 June, 19 66, and that death occurred at 11:20 PM, M, from the causes and on the date stated above.											
22a. SIGNATURE Warren W. Davis					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 24 June 1966				
22c. PHYSICIAN'S NAME (Type) Warren W. Davis, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF JUNE 27, 1966		23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY		23d. LOCATION (City, town or county) (State) LYNCHBURG, VIRGINIA				
24. FUNERAL DIRECTOR WHITTEN FUNERAL HOME, LYNCHBURG, VIRGINIA					25a. REC'D BY REGISTRAR DATE JUN 28 1966					25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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08768

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Germantown, Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown 15 - 1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS Rt. 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kenneth Thomas Wright First Middle Last				4. DATE OF DEATH June 21 1966 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-4-95 AGE (In years last birthday) 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Military		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Wright				14. MOTHER'S MAIDEN NAME Emma Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-44-9926		17. INFORMANT Virginia Metz Wright, As #2 Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Intra-Cranial Hemorrhage DUE TO right complete Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO H.C. U.D. - seven years (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH 5 weeks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 16 1966 to 6-21 1966 , that (I) (we) last saw the deceased alive on 6-20 1966 , and that death occurred at 2:45 am from causes and on the date stated above.							
22a. SIGNATURE Jack Schumacher M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-21-66	
22c. PHYSICIAN'S NAME (Type) Jack Schumacher				22d. ADDRESS Gaithersburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-23-66		23c. NAME OF CEMETERY OR CREMATORY Church Neelsville Presbyterian		23d. LOCATION (City or Town) (County) (State) Germantown, Md.	
24. FUNERAL DIRECTOR Ernest C. Gartner Gaithersburg, Md.				25a. REC'D BY REGISTRAR JUN 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

STATE OF CALIFORNIA
COUNTY OF LOS ANGELES
I, the undersigned, a duly qualified and licensed physician, do hereby certify that the within and foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears from the records of the Department of Health, State of California, at the time and place of the death of the said person.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M
6/25-10/23/66
Warner E. Pumphrey, Inc.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08769 CERTIFICATE OF DEATH 08760											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>D. O. A.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>					d. STREET ADDRESS <u>910 Venice Dr.</u>						
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>George</u> Last <u>ZACHARIA</u>					4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 22 1917</u> 49 yrs.		9. AGE (In years last birthday) IF UNOER 1 YEAR Months <u> </u> Days <u> </u> IF UNOER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>taxi cab driver</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Taxicab</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Johnstown, Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Alex Abraham (Zacharia)</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth X Daley</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>			16. SOCIAL SECURITY NO. <u>577-16-3950</u>		15. INFORMANT <u>Evelyn Zacharia</u>			Address <u>910 Venice Drive Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct, posterior left vent.</u> 4201 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. b) <u>Occulsive coronary arterial atherosclerosis</u> c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>June 25, 1966</u> , to <u>June 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 25, 1966</u> , and that death occurred at <u>10:25</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Walter G. Goetz MD</u>					22b. DATE SIGNED <u>6/25/66</u>						
22c. PHYSICIAN'S NAME (Type) <u>WALTER GOETZ MD</u>					22d. ADDRESS <u>2390 GLENMONT CIR WHEATON MD</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>June 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>				
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>					25a. REC'D BY REGISTRAR <u>JUL 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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Large Hospital Infant, mother left with.

Occasional coronary arterial aneurysms

1968